
 MONTANA CANCER CONTROL PROGRAMS		Breast and Cervical Screening Form		 MONTANA Department of Public Health & Human Services	
Client Name		Phone Number		State ID	
Social Security Number - -		Date of Birth MM / DD / YYYY		Admin Site #	<input type="checkbox"/> Revised

CERVICAL CANCER SCREEN RESULTS

<p>Date of Pap test <u>MM / DD / YYYY</u></p> <p>Pap specimen type <input type="checkbox"/> Liquid <input type="checkbox"/> Conventional</p> <p>Adequacy of Pap specimen <input type="checkbox"/> Satisfactory <input type="checkbox"/> Unsatisfactory</p> <p>Result of screening Pap test</p> <p><input type="checkbox"/> Negative for intraepithelial lesion or malignancy</p> <p><input type="checkbox"/> ASC-US</p> <p><input type="checkbox"/> Low Grade SIL (including HPV changes)</p> <p><input type="checkbox"/> ASC-H</p> <p><input type="checkbox"/> High Grade SIL</p> <p><input type="checkbox"/> Squamous Cell Carcinoma</p> <p><input type="checkbox"/> Abnormal Glandular Cells</p> <p>Date of HPV/DNA test <u>MM / DD / YYYY</u></p> <p>High Risk HPV/DNA test results if done</p> <p><input type="checkbox"/> Positive <input type="checkbox"/> Negative</p> <p>Paid by MCSP</p> <p>Pap test <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>HPV/DNA test <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Reason for Pap test</p> <p><input type="checkbox"/> Routine screening</p> <p><input type="checkbox"/> Surveillance, follow-up of previous abnormal</p> <p><input type="checkbox"/> Done outside the MCSP, diagnostics only</p> <p><input type="checkbox"/> Not done, diagnostics only</p> <p><input type="checkbox"/> Breast record only</p> <p>Date referred to the MCSP for diagnostic workup</p> <p>Date referred <u>MM / DD / YYYY</u></p> <p>Additional procedures</p> <p><input type="checkbox"/> Not planned, normal follow-up</p> <p><input type="checkbox"/> Planned, further diagnostic tests needed</p> <p>Next Pap test or follow-up due <u>MM / DD / YYYY</u></p> <p>Recommendations/comments _____</p> <p>_____</p> <p>Provider's signature _____</p> <p>Print provider's name _____</p>
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<p>Respond for ALL clients screened for cervical cancer</p> <p>Has this client had a hysterectomy? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If "Yes" was the hysterectomy</p> <p>Due to cervical neoplasia? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Is the cervix still present? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>A client who has had a hysterectomy is eligible for an MCSP Pap test if the hysterectomy was due to cervical neoplasia or the cervix is present.</p>	<p>Respond for clients with a NORMAL Pap test result</p> <p>Recommend the cervical cancer screening interval for this client.</p> <p><input type="checkbox"/> Short term follow-up, abnormal protocol</p> <p><input type="checkbox"/> Annual, conventional Pap test</p> <p><input type="checkbox"/> Every 2 years, liquid based cytology</p> <p><input type="checkbox"/> Every 3 years, 3 normal Pap tests within 60 months</p>
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BREAST CANCER SCREEN RESULTS

<p>Date of Clinical Breast Exam <u>MM / DD / YYYY</u></p> <p>Clinical Breast Exam (CBE) findings</p> <p><input type="checkbox"/> Normal exam</p> <p><input type="checkbox"/> Benign findings</p> <p><input type="checkbox"/> Abnormal, suspicious for cancer</p> <p><input type="checkbox"/> CBE not done</p> <p>Date of Mammogram <u>MM / DD / YYYY</u></p> <p>Mammogram type <input type="checkbox"/> Digital <input type="checkbox"/> Conventional</p> <p>Mammography test results - BI-RAD Categories</p> <p><input type="checkbox"/> Negative: Category 1</p> <p><input type="checkbox"/> Benign: Category 2</p> <p><input type="checkbox"/> Probably benign short interval follow-up suggested: Category 3</p> <p><input type="checkbox"/> Suspicious Abnormality: Category 4</p> <p><input type="checkbox"/> Highly suggestive of malignancy: Category 5</p> <p><input type="checkbox"/> Assessment Incomplete: Category 0</p> <p>Paid by the MCSP</p> <p>CBE <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Mammogram <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Reason for Mammography test</p> <p><input type="checkbox"/> Routine screening</p> <p><input type="checkbox"/> Evaluate symptoms, positive CBE/prev abnormal mammogram</p> <p><input type="checkbox"/> Done outside the MCSP, diagnostics only</p> <p><input type="checkbox"/> Not done only received CBE or diagnostics</p> <p><input type="checkbox"/> Cervical record only</p> <p>Date referred to the MCSP for diagnostic workup</p> <p>Date referred <u>MM / DD / YYYY</u></p> <p>Additional procedures</p> <p><input type="checkbox"/> Not planned, normal follow-up</p> <p><input type="checkbox"/> Planned, further diagnostic tests needed</p> <p>Next breast screening or follow-up due <u>MM / DD / YYYY</u></p> <p>Recommendations/comments _____</p> <p>_____</p> <p>Provider's signature _____</p> <p>Print provider's name _____</p>
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